

PATIENT INFORMATION

Name: _____, _____, _____ Male Female
Last First M. I.
 Address: _____
Street City State Zip
 Home Phone: (____) _____ Business Phone: (____) _____ Cell Phone: (____) _____
 Date of Birth: _____ Marital Status: Single Married Divorced Widowed
 SS #: _____ E-Mail: _____
 Driver's License Number: _____ Physician you are here to see _____
 Referred By: _____ Have you or any family member been seen here before? Yes No
 Preferred Pharmacy _____ Address _____ Phone _____

GUARANTOR INFORMATION – *Must be completed* (Patient and/or Responsible Party)

Responsible Party Name _____ Male Female
Last First M. I.
 Date of Birth: _____ Driver's License #: _____ Social Sec. #: _____
Month / Day / Year
 Employer Name: _____ Employer Phone: (____) _____
 Employer Address: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name _____ HMO PPO Private
 Name of Insured _____
Last First M. I.
 Address _____
Street City State Zip
 Date of Birth (Insured) _____ Male Female
Month / Day / Year
 Social Security Number: _____ Insurance ID #: _____
 Group Number: _____ Employer: _____ Occupation: _____
 Relationship to Patient: Self Parent Spouse Other: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name _____ HMO PPO Private
 Name of Insured _____
Last First M. I.
 Address _____
Street City State Zip
 Date of Birth (Insured) _____ Male Female
Month / Day / Year
 Social Security Number: _____ Insurance ID #: _____
 Group Number: _____ Employer: _____ Occupation: _____
 Relationship to Patient: Self Parent Spouse Other: _____

EMERGENCY CONTACT INFORMATION

Name of Person to Contact: _____ Relationship _____
 Address _____
Street City State Zip
 Home Phone (____) _____ Work Phone (____) _____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. Co-payment amounts are subject to final adjudication by my health plan and I understand that any initial determination of my co-payment (from my card or online) is subject to final verification by my health plan. I understand that I will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that our charges will be paid by the Insurance Company. Insurance is an agreement between you and your insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand and agree to hereby give consent for treatment.

Patient's Signature: _____ Date: _____

Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. We will not ask why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. **Some method of contact must be provided**, and as appropriate, information as to how payment will be handled.

I, _____, give my permission for Comprehensive Care Center of Irvine
(Print Name of Patient)
 Physicians and employees to communicate information related to my personal health, as indicated below. This request supersedes any prior request for communication of information I may have made.

Phone

Contact me regarding my test results by telephone. YES NO
 Leave messages on my answering machine/voice mail. YES NO

You may use the following telephone numbers:

Work _____
 Home _____
 Cell Phone _____

You may leave messages regarding my medical information with the following people (Print Names):

1. _____ 2. _____
 3. _____ 4. _____

E-Mail

Send e-mail messages by secured e-mail (Relay Health / NextMD) YES NO

Mail

Send mail regarding appointments, test results, my condition and treatment YES NO

Address: _____

Signature: _____ Date: _____ Date of Birth: _____
(Patient signature, if Patient is a minor then Parent or Legal Guardian must sign.)

Name: _____ Relationship: _____

Acknowledgement of Receipt of Notice of Privacy Practices



250 East Yale Loop, Suite 204, Irvine, CA 92604

Privacy Officer: Kristina Leatherman, Manager (949)732-3530

Effective Date: April 18, 2011

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for the above physicians. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended Notice of Privacy Practices will be made available at my next appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____

Notice of Privacy Practices Acknowledgment Tracking Information

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain: _____

Reasons for refusal: _____

Employee Name: _____

Name: _____ Date: _____
 Birthdate: _____ Previous Primary Physician: _____
 Current Specialists: _____

Medications

Please list any medications with strength that you currently take regularly (including non-prescription)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Please list any allergies to medications, foods or other

<u>Medication</u>	<u>Food</u>	<u>Other</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History

Illnesses/Conditions

Do you have or have you ever had any of the following:

	Year
_____ Anemia	_____
_____ Anesthesia complications	_____
_____ Anxiety	_____
_____ Arthritis	_____
_____ Asthma	_____
_____ Birth Defects	_____
_____ Cancer (type: _____)	_____
_____ Colitis	_____
_____ Concussion	_____
_____ Depression/Nervous Breakdown	_____
_____ Diabetes	_____
_____ Emphysema	_____
_____ Heart Attack/Heart Disease	_____
_____ High Blood Pressure	_____
_____ High Cholesterol	_____
_____ Kidney Disease	_____
_____ Liver Disease/Hepatitis	_____
_____ Migraine Headaches	_____
_____ Mitral Valve Prolapse/Murmur	_____
_____ Osteoporosis	_____
_____ Pneumonia	_____
_____ Rheumatic Fever	_____
_____ Seizure Disorder	_____
_____ Sexually Transmitted Disease	_____
_____ Stroke	_____
_____ Thyroid Disorder	_____
_____ Tuberculosis	_____
_____ Ulcer	_____

Surgical Procedures/Hospitalizations

Year

_____	_____
_____	_____
_____	_____

Childhood Diseases

Year

_____ Chickenpox	_____
_____ Measles	_____
_____ Mumps	_____
_____ Polio	_____
_____ Other: _____	_____

Gynecological History (women only)

Last menstrual period _____

How many pregnancies have you had? _____

How many children do you have? _____

Have you ever had an abnormal pap? _____

Have you had a hysterectomy? _____

Have your ovaries been removed? _____

Health Maintenance

When, if ever, did you last have any of the following:

_____ Cholesterol check	_____ Pap Smear
_____ Colonoscopy	_____ Prostate exam
_____ EKG/Cardiogram	_____ Cardiac stress test
_____ Mammogram	_____ Bone Density

List Year of Last Vaccinations:

_____ Tetanus (TD)	_____ Hepatitis A
_____ TB Skin Test	_____ Hepatitis B
_____ Pneumonia	_____ Shingles (Zostavax)

Health Maintenance continued

Name: _____
Birthdate: _____

Family History

Has any blood relative ever had any of the following :

Relative (mother, father, sister, children)	Living	Deceased
	Age	Age (at death) & cause
Alcoholism _____	Father _____	_____
Asthma _____	Mother _____	_____
Bleeding problems _____	Brother _____	_____
Cancer _____	_____	_____
Type: _____	_____	_____
Diabetes _____	Sister _____	_____
Emphysema _____	_____	_____
Glaucoma _____	_____	_____
Heart Attack _____	Son _____	_____
Heart Disease _____	_____	_____
High Blood Pressure _____	Daughter _____	_____
Mental Illness / Suicide _____	_____	_____
Osteoporosis _____	_____	_____
Seizures _____	_____	_____
Stroke _____	Husband/Wife _____	_____
Thyroid _____	_____	_____

Social History

Marital Status?	Single	Married	Divorced	Widow	Partner
Do you have children / dependents at home?		Yes / No	How many? _____		
Are you employed?		Yes / No	Occupation? _____		
Do you or have you ever smoked or chewed tobacco?		Yes / No	When? _____	Quit date? _____	
Packs/cans/bags per day _____ / yrs _____			Type? _____	How often? _____	
Do you or have you ever used illegal drugs?		Yes / No	Type? _____	How often? _____	
Do you drink alcohol?		Yes / No	Type? _____	How often? _____	
Have you been exposed to toxic substances?		Yes / No			
Do you drink caffeine daily?		Yes / No	Type? _____	How often? _____	
Do you exercise regularly?		Yes / No	Type? _____	How often? _____	
Do you wear seat belts?		Yes / No			
Do you have a living will or advance directives?			Yes / No		
What is your highest level of education?					_____

Review of Symptoms

Please check any of the following that you are experiencing:

General	Fatigue	Fever	Hopelessness	Hot Flashes	Insomnia	Night Sweats	Poor Concentration
	Recent Weight Loss / Gain		Loss of Interest in Usual Activities				
Skin	Change in Pigmentation		Eczema	Hives	Jaundice	Rashes	
ENT	Change in Vision / Hearing		Dizziness	Enlarged Glands	Glaucoma	Headaches	
	Hearing Loss	Neck Stiffness	Nose Bleeds	Chronic Sinus or Ear Problems			
Respiratory	Asthma	Difficulty Breathing	Frequent Colds / Coughing		Shortness of Breath		
	Spitting up Blood						
Cardiac	Angina	Chest Pain	Difficulty Walking 2 Blocks		Heart Murmur	High Blood Pressure	
	Palpitations		Swelling of Hands / Feet				
Gastrointestinal	Abdominal Pain / Cramping		Blood or Dark Stool	Change in Bowel Habits		Frequent Diarrhea	
	Frequent Indigestion / Heartburn / Gas / Bloating			Hepatitis	Hemorrhoids	Vomiting Blood	
Genitourinary	Difficulty Urinating	Frequent Urination	Loss of Bladder Control		Unsatisfactory Sex Life		
Musculoskeletal	Joint Pain or Swelling	Difficulty Walking	Muscle Cramping or Weakness		Varicose Veins		
Neuropsychiatric	Prior Treatment for Depression / Psychiatric Care			Fainting Spells	Paralysis	Convulsions	
Hematologic	Easy Bruising	Excessive Bleeding After Cuts		Slow Healing After Cuts			

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and reports. *Note: Information and records regarding minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorizations.*

I hereby authorize:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: <input type="checkbox"/> Dr. Kalena Hwang <input type="checkbox"/> Dr. Amanda Binns <input type="checkbox"/> Dr. Andrew Siskind <input type="checkbox"/> Sarah Campbell FNP-C	}	At: <u>Comprehensive Care Center of Irvine, Inc.</u> <u>250 East Yale Loop, Suite 204</u> <u>Irvine, CA 92604</u> <u>P: (949)732-3530 F: (949)999-8160</u>
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This medical information / records will be used for the following purpose:
 Change of Primary Care Physician Consult with Specialist Other _____

This authorization is:

- Unlimited (all records including Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
- Limited to the following medical information:
 - Last 2 years of records (progress notes, test results, procedures, immunizations, consults)
 - Test Results
 - Immunizations
 - Other: _____

This authorization shall be effective immediately and remain in effect until _____.
 Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

 Signature of Patient, Guardian / Legal Representative

 Relationship (if other than Patient)

 Patient's Name (PRINT)

 Date of Request

 Patient's Social Security Number

 Patient's Date of Birth

 Witness

 Date Records Sent